

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-005199

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **38** Primary Registration District No. **3006** Registrar's No. **158**

FILED MAR 7 1963

VS 300
Rev. 4/59

1 *0109*

2 *0109*

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4 *3-11-63*

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9 *4200*

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12 *90-0*

13 *3-0*

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO.

SHOULD READ

1. PLACE OF DEATH a. COUNTY <i>Boone</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Boone</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Columbia</i>		Length of stay in 1b <i>799</i>	c. CITY OR TOWN <i>Columbia</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>303 Fisher Walk</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>303 Fisher Walk</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>CASSIE BELLMORE</i>		4. DATE OF DEATH Month Day Year <i>Feb. 26-1963</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>May-1883</i>
9. AGE (last birthday) <i>799</i>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house work</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Boone County Mo. U.S.A.</i>
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME <i>Wood Warren</i>	
13b. MOTHER'S MAIDEN NAME <i>Harriet Hickman</i>		14. NAME OF HUSBAND OR WIFE <i>James Bellmore</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Julia Harris, Columbia, Mo.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause of death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 minute</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerotic Heart disease, indef</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease/condition given in PART I (a) <i>Viral Influenza</i>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <i>1959</i> and last saw her/him alive on <i>1963 Feb 19</i> Death occurred at <i>10:35</i> <i>P</i> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>James Dunnington MD</i>		22b. ADDRESS <i>1009 Chesny Columbia Mo.</i>	22c. DATE SIGNED <i>1 Mar '63</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>Mar. 3-11-63</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Log Providence Cemetery Columbia, Mo.</i>	
23d. LOCATION (City, town, or county)		23e. REGISTRAR'S SIGNATURE <i>Mrs R.E. Palmer</i>	
24. FUNERAL DIRECTOR <i>Mrs Stuart Parker, Columbia, Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>Mar. 2 1963</i>	

USE BLACK INK OR TYPEWRITER RIBBON

MAR 8 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by 0, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harold Warren Jr

Licensed Embalmer No. 5203

P. O. Address Col Md

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.
If this body is not embalmed, fact should be so stated above.